Liability Insurance for California Long-Term Care Providers

A Report to the California Legislature

Governor Gray Davis
State of California

Secretary Grantland Johnson
Health and Human Services Agency

Director Diana M. Bontá, R.N., Dr. P.H.
Department of Health Services

This report was prepared by the Department of Health Services Licensing and Certification Program in response to a mandate by the California Legislature, AB 430 (Ch. 171, Statutes of 2001).

Brenda G. Klutz, Deputy Director

A C K N O W L E D G E M E N T S

This report was completed with the assistance of the following work group participants from the Department of Health Services, the Department of Insurance, the Office of Statewide Health Planning and Development, and the Department of Finance:

Jennifer Sugar
Barbara Hewitt Jones
Shannon Chambers
Grant Gassman
Gene Morrow
Louise Kamikawa
Sean Tracy
Benjamin Gentile
Ty Christensen
George Fribance
Kevin Collins

The Department of Health Services also would like to thank the following people for contributing to the completion of this report, either through submitting materials for consideration, or through meetings to discuss the issues:

Nancy Armentrout, California Association of Health Facilities (CAHF)
Cheye Calvo, National Conference of State Legislatures (NCSL)
Beth Capell, Capell and Associates
Carole Cavanaugh, R.N., Knott Avenue Care Center
Phillip Chase, The Center at Park West
Lesley Ann Clement, Clement & Associates
Judy Citko, California Healthcare Association (CHA)
Lori Costa, California Association of Homes and Services for the Aging (CAHSA)
Elizabeth Devore, NCSL
Joe Diaz, CAHF
John Endicott, Continuing Care Contracts Committee
Paul Goss, Beverly Enterprises, Inc.
Heather S. Harrison, California Assisted Living Facilities Association (CALFA)
Dave Helmsin, CAHF
Anne Burns Johnson, CAHSA
Cindy Laubaucher, Wilke, Fleury, Hoffelt, Gould & Birney, LLP
Hillary Lewis, JD, LL.M, CNA Insurance
Kip Alan Lewis, Lewis & Associates Insurance Brokers, Inc.
Pat McGinnis, California Association of Nursing Home Reform (CANHR)
Sally G. Michael, CALFA
Nancy Peverini, Consumer Attorneys of California
Tom Porter, AARP
Sally Rapp, SR Management Services, Inc.
Jeff Souza, California Healthcare Insurance
Joe Sullivan, Zurich
Nina Weiler, AARP

State agency representatives from various other states also provided information.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Pursuant to Section 53.5 of AB 430 (Chapter 171, St. of 2001), the State Department of Health Services shall convene a workgroup and shall submit a report to the appropriate committees of the Legislature, on the availability and cost trend for general liability and professional liability insurance for long term care providers in California.

DEPARTMENT OF HEALTH SERVICES (DHS) RECOMMENDATIONS

On any average day, approximately 100,000 Californians reside in **skilled nursing facilities (SNFs)** †, another 8,000 reside in intermediate care facilities for the developmentally disabled (ICF-DD, ICF-DD-H, or ICF-DD-N), and over 140,000 live in licensed residential care or assisted living facilities (see Table 1, page 4).

In the United States, "more than 12 million people, 6.6 million of whom are elderly, receive long-term care assistance," according to an April 2002 Issue Brief published by the Commonwealth Fund. [1] "Of elderly **long-term care (LTC)** recipients, 1.5 million reside in an institution such as a nursing home and the remainder receive care in their homes or communities."[2]

When Governor Davis took office in January 1999, concerns about staffing, quality, and the financial stability of nursing homes presented a cloudy picture for future LTC options. By 2020, nine million Californians will be over the age of 60, and it is important that a quality continuum of care is in place.

Almost immediately, the Governor determined that his Administration would establish a firm LTC policy base that would extend beyond a focus on nursing homes only. He began developing a multi-faceted, integrated strategy to improve California's LTC system, his **Aging with Dignity Initiative**. The initiative includes the principles that consumers need options and tools to make wise choices; caregivers need to be qualified and receive support and incentives to excel; and government must maintain a responsive framework to ensure the quality of services.

During this time, a related issue began affecting LTC providers. The insurance industry was increasingly unwilling to write liability insurance coverage, or at least at costs considered reasonable by providers. In the late '90s, Florida was the first State to experience serious problems related to the insurance industry's revised perception of the risks involved in the provision of LTC services.

† **Bold** is used to indicate the first time a term is used, definitions are provided in Appendix A.

In 1999, the House Committee on Elder Affairs and Long Term Care reported:

> Widespread concern was brought to the committee about the ill effects of inadequate direct care staffing in many Florida nursing homes. The number of lawsuits filed against facilities was increasing. Due to the increasing claims, the liability insurance companies began to choose between raising premiums and/or discontinuing the provision of liability coverage altogether.[3]

"Long-term care" focuses on managing on-going conditions over time. Services may include *medical assistance,* such as administering medication or performing rehabilitative therapy. But more typically it involves *personal care*, such as help with bathing and eating, and *supervision*, such as protecting a person from wandering away or inadvertently injuring themselves. The emphasis of long-term care is on enhancing a person's ability to function and enjoy a quality of life rather than on curing a condition."

Long Term Care: Providing Compassion without Confusion,
The Little Hoover Commission, December 1996, Pg. iii.

LTC "focuses on managing on-going conditions over time." [4] This basic definition is recognized by consumers seeking care and by organizations providing care. What has changed dramatically in the last several years, however, is "the rising case complexity in nursing facility admissions"[5], and the element of risk associated with the provision of LTC services.

Seventy percent of residents in SNFs are age 75 and older. For many, this is a temporary placement only—around 80 percent of residents are discharged within six months. However, those residents with serious or chronic health conditions may reside in a nursing home for several years. A SNF is not only a resident's health care provider; it is also that resident's home.

Risk is anything that prevents an organization from accomplishing its mission. Risk is the possibility of suffering harm or loss.[6] LTC providers, like any other residential business enterprise, purchase liability insurance to cover legal liability that might result from injuries to residents, others, or from damage to its property.

"Since 1997, the long-term care industry has faced an increasingly tight market for liability insurance coverage. As the number and size of liability cases against nursing homes grows, the cost of liability insurance policies continues to skyrocket."[7] There is no California State requirement that LTC facilities purchase liability insurance; but without such coverage, even one significant lawsuit could mean bankruptcy or closure.

What the insurance industry determined, through its **claims** experience, was that risk is greater for LTC providers than for other residential businesses. Media exposure of nursing homes, largely focusing on occurrences of abuse, neglect,

and inadequate staffing, combined with increasing **claims frequency** and **claims severity** trends, due to litigation, added to the negative risk perception.

Liability Insurance for California Long-Term Care Providers, A report to the California Legislature, responds to language that is part of the Governor's 2001-2002 Budget Act. While the majority of literature and information available on the subject pertains to nursing homes, liability insurance is an issue for any LTC housing where an element of risk exists. In addition to provider groups representing nursing homes, DHS also received comments regarding the issue of liability insurance from organizations representing ICF-DD facilities and those representing assisted living facilities. Consumer advocate, attorney, and insurer organizations also provided information.

In preparing the report, DHS found the data available regarding nursing home liability insurance are limited, and generate more questions than they provide answers. DHS does have data that indicate premiums are increasing and fewer companies are willing to write liability insurance policies for nursing homes. Frequency and size of claims are also increasing.

A myriad of factors affects cost and availability of liability insurance for LTC providers, and the report's organization identifies four inter-related areas:
- Nursing homes and the liability insurance market,
- Quality of care oversight and reimbursement,
- Enforcement and civil law, and
- Consumer access to quality LTC services.

DHS also has considered information on legislative and regulatory actions taken by other states to address the cost and availability of liability insurance. Insurance market changes occurred so recently, however, that data from other states are still limited, making it difficult to evaluate the effectiveness of changes that have been implemented to date.

The report analyzes and assesses 20 options for action that could affect the cost and availability of liability insurance for LTC providers, based on the literature and experience from other states (see Options for Consideration, pages 83-105). The final section of the report identifies five DHS recommendations for action.

RECOMMENDATIONS

1. Increase DHS data regarding litigation and insurance claims against nursing homes.
2. Increase DHS data regarding cost and availability of liability insurance.
3. Require nursing homes to implement an approved risk management plan as a condition of health facility licensure.
4. Conduct a study to assess the relationship between enforcement and legal actions in recent elder abuse cases.

5. DHS to work with the LTC Council to evaluate the broader implication of the affect of liability insurance issues on all LTC providers.

DHS recommendations focus on securing the information necessary for rational decision-making, and on supporting facility efforts to improve quality by strengthening facility system(s) to reduce losses.

The fact is that when losses do occur, organizations must pay for them somehow. Insurance is one of the many methods available for financing losses. However, insurance does nothing to prevent a loss from occurring. The least costly accident in terms of residents' and staffs' safety, time, money, and morale is the one that never happens.

Nursing Homes and the Liability Insurance Market

A nursing home in its effort to mitigate risk, like any other business, may purchase liability insurance to cover legal liability that might result from injuries to residents, or other persons, or from damage to its property. Such a liability insurance policy would pay for a claim that results from a court award or settlement.

A nursing home has four basic methods for securing coverage:

- A traditional policy through an **admitted insurance company** licensed in California;
- An excess or **surplus line** policy through an insurer not licensed in California;
- **Pooling arrangements** through an agreement where a group opts to share losses and expenses among members of the pool, typically with each paying a predetermined ratio; and
- **Self-insured**, an option mainly used by large organizations. A qualified self-insured is usually required to securitize the loss reserve through cash, letters of credit, and/or bonds.

Admitted companies are the only commercial insurance that must be registered and regulated by the state insurance agency.

A nursing home locates an insurance company to issue or write a liability policy. An insurance company writes a policy that, for a given premium, will cover:

- A defined amount of claims—the maximum coverage—including a designated dollar amount for the maximum coverage allowable for each claim, and a total dollar amount of coverage for all claims payments;
- A predetermined out-of-pocket responsibility of the insured for each claim—the deductible; and
- A specified period of time for the insurance coverage—policy term.

California nursing homes are not required to carry liability insurance or to send information to DHS regarding liability insurance claims filed, premiums paid, or type of coverage held. In May 2001, the California Department of Insurance

(CDI) inquired of the admitted insurers, licensed under its authority, to determine the state of LTC liability insurance availability for nursing homes and assisted living facilities in California between 1999 and 2000. The information was useful in preparing this report; however, it also revealed that only 13 percent of California nursing homes had policies with these state licensed insurers.

DHS also determined that Section 1305 of the Health and Safety (H&S) Code currently includes a requirement for liability insurers to report at least annually to DHS regarding claims activity against nursing homes. Insurers are to report any final judgment or settlement over $3,000 rendered against a facility for which they are providing liability insurance coverage. Although this language has been part of the H&S Code for 30 years, DHS found no documentation to indicate that the provision was implemented. The language in the H&S Code is similar to provisions in Section 801 of the Business and Professions (B&P) Code. That section requires every insurer providing professional liability insurance to physicians, to report to the California Board of Medical Quality. Insurers were to indicate any settlement awards over $3,000, or a claim or action for damages for death or personal injury caused by the physician's negligence, error or omission in practice or rendering of unauthorized professional services.

Several possible insurance market approaches exist that could be developed to assist LTC providers in securing liability insurance for their facilities. A state **joint underwriting association (JUA)** could be established to pool LTC liability insurance risk; CDI could investigate ways to expand the types of insurance companies with California licensure; or CDI could explore modifications to the rate structure for liability insurance. Several states are evaluating a JUA or other state sponsored risk pool. In 2001, Texas opened its JUA to for-profit nursing homes. Previously only non-profit facilities had access. To date, only a few facilities have chosen to use the Texas JUA for liability insurance.

Health and Safety Code, Section 1305. Insurers; report of judgments and settlements

(a) Every insurer providing professional liability insurance to a health facility licensed pursuant to this chapter and every health facility or associated group of health facilities licensed pursuant to this chapter under common ownership which are self insured shall report periodically, but in no event less than once each year, to the state department any final judgment over three thousand dollars ($3,000) rendered against such health facility during the preceding year of, a claim or action for damages for personal injuries caused by an error, omission, or negligence in the performance of its professional services, or by the performance of its professional services without consent.

(b) In the event that there are no final judgments or settlements in excess of three thousand dollars ($3,000) during the year such fact shall also be reported to the department. (Added by Stats. 1973).

Recommendation 1.
DHS, in consultation with CDI, the Medical Board of California, and OSHPD, will implement a system, effective January 2004, to notify all nursing homes, and liability insurance carriers, of the reporting requirements specified in Section 1305 of the Health and Safety Code (see Inset).

Implementation of this statute will provide useful data regarding final judgments or settlements over three thousand dollars rendered against a health facility and specified claims or actions for damages.

In addition, in October 2002, the Administration announced a consumer protection initiative to aid nursing home residents. One of its provisions required nursing homes to report all civil and criminal court actions filed against the facility to DHS.

Recommendation 2.
DHS, in consultation with CDI and OSHPD, will determine by December 2003, the need for a regulatory or statutory change to mandate that nursing homes provide specific basic information on liability insurance coverage, at the time of application for health facility licensure, and at the time of license renewal annually thereafter. The evaluation will utilize:

- CDI information secured from licensed or admitted insurers in the State (representing coverage for approximately 13 percent of nursing homes);
- OSHPD information secured under current financial reporting requirements for nursing homes;
- Information generated from a survey conducted by DHS, to be issued late 2003, of all nursing home owners regarding their current method of coverage and policy structure, including premiums, deductibles, and policy terms.

Quality of Care Oversight and Reimbursement

California is home to an array of LTC programs. A December 2000, Medi-Cal Policy Institute report, "The Role of Medi-Cal in California's LTC System," documented more than 74 public LTC programs and related services housed in six state agencies, with expenditures of at least $13.5 billion in 1998. Within those programs, what constitutes a long-term care facility also can vary depending on who uses the term and for what purpose.[8]

LTC is big business, and aging baby boomers will continue to make it a potential growth market. Many of the larger nursing facility and assisted living companies are publicly traded on the stock market. The nursing home industry currently comprises the largest part of LTC business, with national spending in 2000 of $92.2 billion.[9]

Nationwide, however, there is general dissatisfaction with the quality of care provided in nursing homes. According to a recent national survey:

> Majorities of the public believes that nursing homes are understaffed… that nursing home staff are often poorly trained, that at least some nursing home residents are abused and neglected, that many residents do not have enough privacy…and that many residents are lonely.[10]

Yet nursing homes are one of the most regulated of health care providers. A DHS Licensing and Certification (L&C) team of trained health professionals conducts an intensive **survey** of each California nursing home at least once every 9 to 15 months. The inspections average over 150 hours and include not only examination of administration and physical plant, but also an assessment of the quality and adequacy of the care. The survey team members review quality indicators based on patient assessment data, and observe, interview, and review medical records to determine compliance with federal and state requirements. Surveyors conduct onsite visits to investigate all **complaints** against nursing facilities. If there is an immediate and serious risk to a resident, the investigation will take place within 24 hours of the call.

Almost 15 years ago, the federal government established a framework to ensure the provision of quality services to nursing home residents whose care is paid for by the **Medicare** and **Medicaid** programs. Today, the **Center for Medicare and Medicaid Services (CMS)** continues to take additional steps to emphasize quality of care, outcome measurement, and empowerment of consumers through provision of detailed information from which to evaluate nursing home care.

The Davis Administration quickly perceived that to improve LTC in California, quality needed to be defined in broader terms, ones that also recognized the direct relationship between quality of care and the financial stability of the facility where care is being provided. Aging with Dignity, through legislation, the budget, and administrative actions, already has significantly strengthened the State's systems that oversee the provision of LTC services.

For example, multiple units are involved in oversight of nursing home payments, including DHS Medical Care Services (MCS), Electronic Data Systems (EDS), the fiscal intermediary contractor, OSHPD, and DHS Audits and Investigations (A&I). L&C involvement in reimbursement oversight had been limited, since its focus was licensing of nursing homes, compliance with federal and state quality standards, and enforcement actions against facilities. The passage of Administration sponsored legislation (AB 1075, Chapter 684, St. of 2001), requires a facility-specific rate-setting system that reflects the costs and staffing levels associated with quality of care for residents in nursing facilities. L&C is now scheduling clinical reviews and financial audits to validate **Minimum Data Set (MDS**), or clinical data, submitted by nursing homes. These data are used for care planning, and are utilized by the federal government to assess patient

acuity and appropriateness of services provided. MDS will be considered in developing the facility specific rate methodology for Medi-Cal.

By further integrating performance and quality improvement into its nursing home oversight systems, Medicare and Medi-Cal will be providing information useful to evaluating positive performance of nursing homes in the area of quality and staffing.

Risk management and loss control, quality assurance, and compliance programs are all methods a nursing home may use to improve performance by correcting systemic issues and problems that increase the risk of a lawsuit or an enforcement action.

Risk management has been defined as the "process of planning, organizing and controlling the resources of an organization in order to minimize the adverse effects of accidental loss on that organization at the lowest possible cost." The typical steps involved in the process are:

- Identify potential loss-producing situations.
- Analyze and quantify loss exposures to determine the frequency and severity of exposure and the impact they will have upon the operation of the agency.
- Evaluate alternative methods of identifying and treating exposures. Methods include loss prevention (loss reduction) and financing through either self-funding or purchase of commercial insurance.
- Implement the chosen decisions.
- Monitor the performance of the chosen decisions and modify the program as necessary.

Risk Management Handbook, from Idaho Office of Insurance Management, Risk Management (1999).

"State of the Insurance Market," is published by the American Association of Homes and Services for the Aging (AAHSA), as a resource document for its members. The author, Sharon Fine of Aon/Huntington Block Insurance, identifies risk management and loss control as an important method for facilities to deal with the current insurance crisis.[11] The nature of the insurance industry is to gain predictability and consistency.

Consumer advocate, insurer, and provider organizations concur that risk management is crucial in efforts to improve the quality of care provided in nursing homes.

According to an article in the June 2001, California Advocates for Nursing Home Reform (CANHR) newsletter:

> Instead of spending millions of dollars to lobby Legislators to curtail the right of abuse victims, the nursing home industry should spend those dollars to establish a Risk Reduction Program and work with the insurance industry to identify high-risk facilities, intervene and provide technical assistance to improve facilities. Insurance companies always spread the risk of liability. Thus, a handful of high risk, frequently sued facilities or chains will increase premiums for all.[12]

California currently has no requirements that a nursing home establish a risk management program. The goal of a risk management program is to minimize

the cost of risk. It is an ongoing and active effort to identify hazards and prevent losses before they occur. An effective risk management program becomes an integral element in the organization's culture and part of the fabric of routine operations.

Recommendation 3
DHS will explore regulatory or statutory changes to require nursing homes to develop and implement a risk management plan that is approved by DHS as a condition of licensure. The requirements will identify the basic components that a facility's plan must include to comply. In general terms, the proposed risk management requirement is summarized below:

Structure

- Risk manager (full-time for a facility of 50 beds or more).
- Risk management committee with ongoing delegated authority to specific individuals for the day-to-day operation of a loss control program.
- Internal processes to provide organizational integrity and corporate compliance with all local, state, and federal laws and regulations.
- Training program for new employees and ongoing coordination of in-service training.

Basic Components

- Regularly planned risk assessments, to identify areas of risk in the facility.
- Risk management committee will develop the risk management plan. The risk information must be translated into decisions and mitigating actions.
- A plan for implementing corrective action, including establishing an early reporting and coordinated response procedure.
- A plan for tracking and evaluating the effectiveness and overall performance of the program.
- A program audit that includes a written plan to monitor and test safety and risk avoidance programs.
- A communication system that establishes a process for submitting suggestions or concerns to the risk manager or the risk management committee. A safety and risk avoidance manual describing the organization's structure and approach for maintaining a safe environment to be provided to staff, volunteer personnel, residents and family members.

Documentation

- Action plan and specific priorities for focused efforts of risk mitigation;
- Corporate compliance plan;
- Claims summary and trend analysis—trending should include evaluation of both claims frequency and severity;
- Required document check list; and
- Risk management committee minutes of meetings.

Required Reporting to DHS

- Risk management plan.
- Quarterly generated claims summary with the organization's trend analysis. Starting in 2006, DHS will publish industry benchmarks for risk management, identify industry trends in claims experience, with mean values as well as one and two standard deviation values.

DHS Technical Assistance

- To act as a resource to facilities requesting additional assistance with establishing their risk management programs, or in addressing risk mitigation in any one of the organization's focus areas.
- To act as a resource to liability insurance providers that have questions regarding the information available about LTC facilities that is generated by the regulatory oversight process.

Enforcement and Civil Law

The Medical Injury Compensation Reform Act (MICRA) of 1975 and the Elder Abuse & Dependent Adult Civil Protection Act (EDACPA) of 1991 form a strong foundation of civil law in California. These two Acts recognize the importance of health and safety considerations for all citizens, and the right of individuals, especially the elderly and dependent, to protection from abuse and neglect (see Appendix E).

MICRA prescribed parameters for civil actions against medical providers at a time when the Legislature determined that escalating malpractice insurance costs threatened access to medical treatment for Californians. The focus of MICRA in 1975 was physicians, but the definition of "health care provider" in the statute also included health facilities.

EDACPA provided enhanced remedies for elderly victims of abuse and neglect when the Legislature determined that without such special provisions, deserving individuals were systematically being denied cause of action under MICRA and other statutes.

Neither California provider organizations nor consumer advocates are arguing that provisions for MICRA or EDACPA should be eliminated entirely. Other states have focused on several basic areas of civil law in their effort to resolve problems with availability and cost of liability insurance:

- Pre-suit requirements to encourage parties to resolve the claim, if possible, before the case goes to court.
- Statute of limitations for cases to enable more predictability for facilities and insurers, reducing the number of cases that might come up from earlier time periods.
- Determination of reasonable attorneys' fees to enable more predictability for facilities and insurers regarding the costs associated with a claim/case.
- Modification of **punitive damages** requirements for elder abuse cases. Punitive damages "punish" the defendant for egregious, deliberate, or harmful

misconduct. Punitive damages normally are not insurable and are paid directly by the nursing homes. A punitive damage claim, however, also increases the overall amount for which an action may be resolved.

In California, consumer advocates and providers disagree about the causes for problems with availability and cost of liability insurance. Liability insurance, by definition, covers a facility's legal liability that might result from injuries to residents or others. Consumer advocates and attorneys believe that increases in the frequency and amount of settlements and awards in lawsuits against nursing homes reflect poor care being provided. "Insurance rates increase as risk increases among nursing homes that are not providing adequate quality of care."[13]

Providers believe that the prevalence of litigation is due to overly aggressive attorneys that actively solicit cases, encourage suits and inflate claims. Providers also do not see an "empirical relationship between facilities' experiences and the increased cost" of liability insurance.[14]

The State has little information on whether civil litigation against nursing homes is threatening consumer access to LTC options by creating problems of availability and cost of nursing home liability insurance. Implementation of **Recommendation 1** of this report (see page 4, Executive Summary, and page 105, Recommendations) should provide additional data on this subject, since it requires liability insurers to report specific claims, judgment and settlement information to DHS.

The State also has limited information to demonstrate that **civil actions** have improved quality of care in nursing homes. DHS conducts onsite inspections of licensed health facilities on a periodic basis, and in response to complaints filed by the public. At the completion of the inspection, surveyors prepare a report to the facility listing violations of various laws and regulations. The facility is then required to prepare a **Plan of Correction (POC).** After the POC is accepted, a follow-up visit can be scheduled to ensure that all needed corrective actions have been taken. The policy behind this process is straightforward—when problems are found in health facilities, those problems should be corrected as soon as possible.

DHS also works closely with the Bureau of Medi-Cal Fraud and Elder Abuse within the Office of the Attorney General on elder abuse cases. Whenever DHS receives a complaint that alleges abuse, neglect, or misappropriation of resident funds or property, DHS notifies and faxes a copy of the complaint to the Bureau. DHS continues to investigate the complaint and provides documentation and assistance should the Bureau decide to prosecute.

L&C inspection findings can be, and are currently used in civil litigation, particularly with respect to nursing homes. Neither the act of providing a POC, nor its contents or implementation, however, may be used in any legal

proceeding as an admission by the facility that the violation leading to the POC occurred. This is consistent with provisions in the Evidence Code to the effect that evidence of remedial conduct cannot be used to prove negligence or culpable conduct related to the event that caused the remedial action to be taken. The policy premise is to promote timely and appropriate remedial action. Current law does not absolutely prohibit admission of a POC into evidence, but the courts allow it only within the context of the Evidence Code.

If a case results in punitive damages, or in a significant settlement award, no analysis has been undertaken to assess the relationship of DHS enforcement actions, civil actions, and Bureau of Medi-Cal Fraud and Elder Abuse actions. More than anecdotal information is necessary if DHS is to recommend changes to the two acts that govern civil law for medical liability and elder abuse cases.

Recommendation 4.
DHS, in consultation with the Office of the Attorney General, Bureau of Medi-Cal Fraud and Elder Abuse, by January 2004, will complete a review of available elder abuse cases that resulted in settlements or punitive damages. The review will address court documents, DHS enforcement actions, performance indicators, and trend data preceding and following the civil action.

Consumer Access to LTC
Access is the freedom or ability to obtain or make use of LTC services. If a LTC provider loses or fails to maintain liability insurance coverage, it places the facility at risk of bankruptcy or financial insolvency should civil litigation be filed against it.

The responsibility of government in the LTC market is to ensure that high quality services are provided by facilities, through a system of licensing and regulatory oversight and enforcement. In the event that a regulated facility closes, government is responsible for ensuring the rights of the resident continue to be protected.

The majority of available information for this report focuses on the cost and availability of liability insurance for nursing homes. Escalating liability insurance costs and difficulties in coverage, however, affect the financial picture for all types of senior housing, such as ICF-DD facilities, and assisted living.

The California Health and Human Services Agency (CHHS) administers state and federal programs for health care, social services, public assistance, job training, and rehabilitation. Responsibility for administering the major programs that provide direct services to millions of Californians is divided among the agency's 15 boards and departments. For example, DHS and the Department of Social Services (DSS) are within CHHS. DHS has authority for licensing health facilities, while DSS is responsible for licensing Residential Care for the Elderly (RCFE) facilities that provide assisted living services.

Governor Davis signed legislation in 1999 to establish a Long-Term Care Council within CHHS. One of its main objectives was to create a framework to address issues collaboratively across state departments that affect quality and access to LTC.

Recommendation 5.
DHS will provide the LTC Council with the report, *Liability Insurance for California Long-Term Care Providers, A Report to the Legislature,* and provide any consultation necessary to assist the Council.

Further Considerations

What further complicates the provision of nursing home care, however, is the significant role government also plays as the major provider of funding. In California, Medi-Cal pays for over 51 percent of nursing home costs, and Medicare 17 percent. The total estimated Medi-Cal expenditure for fiscal year 2002-03 for nursing homes and ICF/DD facilities is $3.1 billion, or approximately 12 percent of all Medi-Cal expenditures.

Costs paid for by residents or their families through LTC insurance or other payers is growing, but is still a relatively small number, only 11 percent.

In order to support expanded use of LTC insurance, DHS established an innovative program, the **California Partnership for Long-Term Care**, in cooperation with a select number of private insurance companies. These companies offer high quality policies that must meet stringent requirements set by the Partnership and the State of California. The Partnership LTC insurance not only pays out benefits when required, it also seeks to protect the policy holders from having to spend down assets, and it seeks to protect those assets from Medi-Cal estate recovery.

As one method to ensure an adequate LTC continuum in the future, California, and the federal government will continue to focus on expanding the use of LTC insurance to improve access to LTC services:

> A revenue source in its infancy, long-term care insurance generates a very small portion of nursing facility revenue. Very few aging Americans buy private long-term care insurance and when they do it is often initiated at an advanced age—defeating the purpose of the insurance design. Inevitably, unless this trend is reversed, likely through changes in tax policy, the growing financing burden will remain on the taxpayer base and present rapidly increasing fiscal pressure on the public programs—Medicare and Medicaid.[15]

Implications

LTC providers, like any residential businesses, purchase liability insurance as part of their overall risk management plans. Without such coverage, even one significant lawsuit could mean bankruptcy or closure.

On the other hand, when a lawsuit is filed against a LTC provider, that action may represent a serious issue, directly related to poor resident care. That action could reflect that current oversight, regulation, and enforcement were not sufficient to ensure resident safety.

Promoting a continuum of high quality LTC services for California's elderly and disabled is a major principle of the Governor's Aging with Dignity Initiative. Provision of care, however, is a consumer service and a business enterprise. There are no "quick fixes." Solutions must always consider quality outcomes, impact on business operations, and access to care.

[1] Juliette Cubanski and Janet Kline, "In Pursuit of Long-Term Care: Ensuring Access, Coverage, Quality," an *Issue Brief*, The Commonwealth Fund, April 2002, p. 1. www.cmwf.org.
[2] Ibid.
[3] Florida House of Representatives, *Final Report: Select Committee on Liability Insurance for Long Term Care Facilities*, March 15, 2002, p. 6.
[4] Little Hoover Commission, *Long Term Care: Providing Compassion without Confusion,* Sacramento, CA, December 1996, p. iii.
[5] Tom Scully, "Health Care Industry Market Update Nursing Facilities," CMS, February 6, 2002, p. 6, www.cms.gov.
[6] The Continuing Care Accreditation Commission in Sharon Fine, AON/Huntington Block Insurance for the *American Association of Homes and Services for the Aging,* "State of the Insurance Market," p. 8.
[7] Elizabeth Devore, "Nursing Homes: The Escalating Liability Crisis," National Conference of State Legislatures (NCSL) Tracking Service, February 2002, p. 1.
[8] Charlene Harrington, *The Role of Medi-Cal in California's Long-Term Care System*, Medi-Cal Policy Institute, San Francisco, CA, December 2000, p. 1.
[9] Scully, op.cit.
[10] The Health Unit, *National Survey on Nursing Homes, Highlights and Chartpack*, The NewsHour with Jim Lehrer/Kaiser Family Foundation/Harvard School of Public Health, October 2001, p. 1. www.kff.org.
[11] Fine, op.cit., p. 4.
[12] CAHNR's Legal Network News—June 2001, p. 6. www.canhr.org.
[13] Rob Cartwright, Jr., Testimony before the California Legislature, Joint Informational Hearing on "Nursing Home Closures, Bankruptcies and Liability Insurance: Is There a Crisis?" on March 6, 2002.
[14] Anne Burns Johnson, Testimony before the California Legislature, Joint Informational Hearing on "Nursing Home Closures, Bankruptcies and Liability Insurance: Is There a Crisis?" on March 6, 2002.
[15] Scully, op.cit., page 18.